# **Settlement agreement for an amount owing to Discovery Health Medical Scheme 2024**



### Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

#### Contact us

Tel (members): **0860 99 88 77**, Tel (health partners): **0860 44 55 66**, <u>www.discovery.co.za</u>, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

## Purpose of the form

This form is your acknowledgement and agreement to pay back an amount owing to Discovery Health Medical Scheme. All amounts due will be indicated below.

# What you must do

- Fill in the form in black ink and print clearly or complete the form digitally. You can view the list of approved digital signature providers on <a href="https://www.discovery.co.za">www.discovery.co.za</a>, under Medical Aid > Find documents and certificates > Application forms.
- All relevant sections must be signed by the main member.
- To avoid administrative delays, please make sure this form is completed in full.
- Please include a letter of confirmation from the bank (not older than three months).
- Please upload the completed form through our Get Help service on <u>www.discovery.co.za</u> under Medical Aid > Get Help > Submit a
  document and follow the guided steps through our Virtual Agent.

1. Main member's	details and	I acknow	ledgeme	nt of am	ount own	ng									
First name(s)															
Surname															
Membership number							Da	te of birth	n D	D N	M	Υ	Υ	Υ	Υ
ID or passport number															
Telephone (H)						Telep	hone (W)								
Cellphone															
Email															
By signing this form, you the quotation attached is changes after this arran	s based on tl	ne informat	ion we hav	ve at the t	ime and da	te of the quo	tation and	if the am	ount y	ou ov	ve to	the S	Scher		n
Signature of main memb	ber														
	lack	Please onl	y sign if in	formation	is true, com	plete and cor	rrect.								

As part of Payment Association of South Africa (PASA) debit order mandate requirements you are required to supply the account holders residential address, email address and contact number. Please note that the details you supply will only be used for the PASA debit order mandate requirement and will not be used to update the contact details we have on system, if you wish to update any contact details please visit <a href="https://www.discovery.co.za">www.discovery.co.za</a> > Medical aid > Manage your health plan.

2. Method of paym	ent										
Please choose your met	thod of pa	ıyment:									
Direct debit (plea	se comple	ete section	3)	Direct depos	sit		Date	D M	MY	Y	Υ
Amount owing R											
If you choose to pay the	e outstand	ing amount	by direct d	leposit, please	use the following bank	account:					
Account holder: Discove	ery Health	Medical Sc	heme								
Bank FNB											
Branch JHB Corporate											
Branch code 255005											
Account type Current											
Account number 58861	132934										
Please use your Discove proof of payment via the the guided steps through	get help s	service or g									
3. Your banking de	etails if y	ou are pa	ying by d	lirect debit							
Bank name											
Branch name					Branch coo	le					
Account number					Type of accou	nt Chequ	ue	Savings	<b>3</b>		
Account holder											
Full amount owing	R					To be debite	ed on*	D M	M Y	Y	Υ
* If the form is not receiv same day you specified By signing this direct de bank account and confir	or the followers	owing worki	ng day.	•							
	y claims, lobove shou Discovery c. at the acco	osses or da uld this acco Health Med ount listed a	mages of vunt have in lical Schemen.	whatsoever nat nsufficient fund ne to verify the tive and has no	ture arising out of debits is, be incorrect or be he banking details as prov ot been de-activated due	made by D d in the nan ided above	iscovery hae of any of the pure	Health Mother pe	ledical S rson. of setting	Scheme	e to the
Signature of account hol	lder										
		A Plea	se only sig	n if information	is true, complete and co	rrect.					
Signed at (town and city	<b>/</b> )						Date	D M	M Y	Y	Y
Signature of main memb	per										

A Please only sign if information is true, complete and correct.